Chapter 2: Changes in the Current System

State Plan implementation has become the central, overarching priority of the Division and all of its components. The Division has a strong, visionary leader in Dr. Richard Visingardi, experienced in managing the challenges and avoiding the pitfalls, of large system reform. A reorganization of the Division that more fully supports and facilitates the State Plan has been developed for gradual implementation. More information about the reorganization is included as a technical document.

Eight months after the release of *State Plan 2001: Blueprint for Change,* active movement toward reform is already changing the landscape of the current system. Citizens in the state have heard about the State Plan either directly from state staff, in local forums, through newspaper articles or at the Department web site. Information sharing at this point is moving beyond presentation of the State Plan's basic concepts and on toward the more technical and complicated tasks of implementation.

Stakeholders at every level - state, counties, LMEs, providers, consumers, families and advocates - are working together to make the system envisioned in the State Plan a reality. Many are donating hundreds of hours in workgroups and committees convened to develop the details of reform components. Additionally, the Division receives many messages of support, areas of concern, extremely valuable suggestions and recommendations for implementation from system stakeholders around the state. Each of these is studied and considered for possible inclusion. The experience and expertise that these observations bring to the reform process are enormously helpful.

System change is underway at the local level. County governments have explored options for merger with other counties and decided on their preferred governance model. Letters of intent from county commissioners are being received. A significant number of area programs have requested to be considered as part of the first phase in becoming an LME in the new system. Most of the area programs that currently serve these counties will be among the first group to assume their new role as LMEs and phase in the new system. Some have proposed to pilot or model various components of the State Plan as learning and testing tools for eventual statewide implementation. The Division is reviewing these requests on a case-by-case basis. A list of these counties and area programs (LMEs) as of June 17, 2002 is displayed below:

Area Program	Counties	Consolidation
CenterPoint Human Services	Davie, Forsyth and Stokes	
Pathways Mental Health, Developmental Disabilities & Substance Abuse	Gaston, Lincoln and Cleveland	
Mecklenburg	Mecklenburg	
Albemarle Mental Health Center & Developmental Disabilities & Substance Abuse Services Roanoke Chowan Human Services Center	Camden, Chowan, Currituck, Dare, and Pasquotank Bertie, Gates, Hertford and Northampton	Pending
Piedmont Mental Health, Developmental Disabilities & Substance Abuse Services VGFW Area Authority	Cabarrus, Rowan, Stanly and Union Vance, Granville, Franklin and Warren	
Duplin-Sampson Mental Health, Developmental Disabilities & Substance Abuse Services	Duplin and Sampson	
Wayne County Mental Health Center Lenoir County Mental Health, Developmental Disabilities & Substance Abuse Center	Wayne Lenoir	Pending
Smoky Mountain Center for Mental Health, Developmental Disabilities & Substance Abuse Services	Cherokee, Clay, Graham, Haywood, Jackson, Macon and Swain	
Blue Ridge Center for Mental Health, Developmental Disabilities & Substance Abuse Services Trend Area Mental Health, Developmental Disabilities & Substance Abuse Authority Rutherford-Polk Area Mental Health Developmental Disabilities & Substance Abuse Authority	Buncombe, Madison, Mitchell and Yancey Henderson and Transylvania Rutherford and Polk Counties	Pending
Edgecombe-Nash Mental Health, Developmental Disabilities & Substance Abuse Services Halifax Wilson-Greene Area Mental Health, Mental Retardation, & Substance Abuse Services	Edgecombe and Nash Counties Single county Wilson and Greene	Pending
O-P-C Mental Health Developmental Disabilities & Substance Abuse Authority	Orange, Person and Chatham	
Wake County Human Services	Single county	
New River Behavioral HealthCare	Alleghany, Ashe, Avery, Wilkes and Watauga	
Neuse Center Mental Health, Mental Retardation, & Substance Abuse Services	Carteret, Craven, Jones and Pamlico	

SERVICES AND PROGRAMS

Building a system of supports, treatment and services for people with disabilities that makes it possible for them to live meaningful and satisfying lives in communities of their choice is a gradual process influenced by many considerations. Progress needs to occur on a number of fronts simultaneously, such as building infrastructure, developing community capacity and acquiring skills needed to apply best practice models that are shown to result in positive outcomes for people. The changing system must also continue to provide needed services to people without interruption during the change process and support them through transition periods. First steps toward the community-based system called for in the State Plan are reducing system reliance on institution/facility care and moving to a person-centered support and treatment approach.

Community service expansion

Planning groups, consisting of area program and Division staff, have met throughout the state's geographic regions to generate service expansion plans. For state hospitals, regional planning groups have determined the type and number of hospital beds slated for closing and identified the types of treatment, services and supports needed in communities to sustain and support individuals out of state hospitals. These may include key service elements such as Assertive Community Treatment Teams (ACTT), supported housing, transportation, medication management, psychosocial rehabilitation, case management and others. Ultimately, expansion plans need to specify what services are needed, when they will be implemented (prior to the specified bed closures) and at what cost. Similar work is going on regarding the state children's residential programs and mental retardation centers.

Much of the current work on building community capacity is occurring in connection with the Olmstead Plan initiative. Individuals who have been hospitalized longer than 60 days have received Olmstead assessments and personal preference interviews. Further information on specialty service and support needs are being gathered from hospital social work and treatment staff and area program personnel. Area program, hospital and Division staff is working on improved guidelines to ensure that there is a high degree of collaboration between the state and local service systems on discharge planning.

Downsizing activities

By the end of June 2002, the mission of the state psychiatric hospitals will have begun to narrow, consistent with the State Plan. The certified nursing facility service units at Broughton and John Umstead hospitals have been eliminated, and the one at Cherry Hospital reduced. The individuals cared for in these units have been transferred to community nursing facilities where necessary capacity was already in place.

The Wright Transitions program at Dorothea Dix Hospital will close by June 30, 2002. At the time that funding was allocated to expand community services, there were 27 people being served by the program. Of these, 14 have been discharged to community services. Five of the 14 have moved into transitional housing, nine have moved into supervised group settings such as family care homes or group homes. Five of the current Wright program residents are unlikely to be ready for discharge in the immediate future and will be transferred to other units of the hospital. Discharge planning is proceeding for the remaining eight residents. In nearly every case, either area program staff visited the resident in the Wright program, or hospital staff transported the resident to the receiving area program and providers in order to build rapport before discharge. Since the majority of Wright program residents will reside in Wake County, Wake Human Services Department staff and Dix hospital staff are meeting weekly to ensure that discharge plans are progressing appropriately.

"There is a need for special transitional services to support those people who will be leaving the institutions and moving into the community."
State Plan feedback

The Division is closely monitoring the discharge process and must approve all discharges from the program. All people discharged from the hospitals as part of the State Plan downsizing effort will be carefully monitored and tracked to ensure that their needs are met in the community settings they enter. Monitoring will include submission of a monthly service tracking form for each client, monthly review of community stability outcome measures, and monthly on-site visits by Division staff to meet with clients and/or review the progress of each individual discharged from the program.

Proposal for consolidated hospital

The physical condition of the four state psychiatric hospitals is a constantly increasing drain on scarce system resources. Some of the hospitals date from the mid-nineteenth century, during the rise of the institution era. Others were pressed into use as hospitals, but built for a different purpose. All of them have been cobbled together at different times over the years in response to different needs; none of them is designed for efficient staffing; all of them are aging and in need of replacement or major renovation.

As part of the plan to reduce the total number of state psychiatric beds and find a long-term solution to the staggering costs of maintaining old facilities, Secretary Hooker-Odom has proposed a plan to consolidate two of the four state hospitals and build a single new facility in their place. John Umstead Hospital, serving 15 counties and seven area programs in the north central region of the state and Dorothea Dix Hospital, serving 16 counties and eight area programs in the south central region, would be closed. The new state-of-the-art hospital would serve a combined central region, consisting of 26 counties and 13 current area programs, with a combined population of 3,232,098 (July 2001 data). In this plan, two area programs are proposed to realign with the eastern region to more evenly balance the scope of geographic areas covered by the hospitals. Several possible sites in the proposed new central region are under consideration for the new

facility. The proposed design would closely resemble the design previously developed for a new Dorothea Dix Hospital.

Renovation and expansion of alcohol and drug abuse treatment centers (ADATCs)

Plans are underway to expand the capacity of the ADATCs to provide acute crisis/detoxification services, thereby diverting people with substance abuse from admission to state psychiatric hospitals. These plans include design, development and renovations at Julian F. Keith ADATC, Black Mountain, an 80-bed residential treatment facility serving residents of western North Carolina; Walter B. Jones ADATC, Greenville, a 76-bed, short-term residential treatment center serving 33 counties in the eastern region and five counties in the south central region; and Butner ADATC, at Butner, a 60-bed acute and rehabilitation center serving sixteen counties of the north central region and ten counties of the south central region. The state has selected and contracted with architectural design firms, and the work has begun. Funding for these projects was obtained through the Mental Health Trust Fund.

Nursing beds expansion

Plans are underway to expand the intermediate and skilled nursing level beds in the western region. Black Mountain Center, Black Mountain, currently serves 73 residents. Expansion will provide increased bed capacity and a mission that more closely matches the mission of the NC Special Care Center, Wilson.

Whitaker School closure

Whitaker School is a residential treatment center located on the grounds of John Umstead Hospital, Butner, for 38 youth, ages 12-17. The condition of the present facility is such that the program cannot continue to operate in its present location. Additionally, the state wants to expand the program's re-education model of treatment, one that has proven successful, to other areas of the state. With funding from the Mental Health Trust Fund, two new centers are being developed to serve 18 adolescent boys and girls. The new units are scheduled to begin operation by December 2002, with full closure of the current Whitaker School facility by July 1, 2003.

Integrated payment and reporting system (IPRS)

This initiative will eventually replace three existing systems of claims processing. It is designed to solve many technical problems of information and data collection and management. It will be built on the existing Medicaid Management Information System (MMIS) currently used to process Medicaid claims for the Division of Medical Assistance (DMA). IPRS has been piloted in two area programs and is scheduled to phase in statewide rollout from July 1, 2002, through June 30, 2003. Target population changes contained in this State Plan revision are currently being programmed into the IPRS system to be used for eligibility determination. Over the next year, the treatment,

services and supports comprising the benefit packages for people served by the reformed system will be added for implementation on July 1, 2003.

More detailed information on overall implementation activities and their scheduled timelines are presented in the part of this Plan describing the state strategic business plan. The work of implementation committees and workgroups and other information and updates about system reform developments is posted regularly on the Department web site.

State system reform is being implemented over a five-year period. Clearly, those years will consist of hard work; people in and outside of the mh/dd/sa system must work to overcome challenges and barriers, build and nurture new partnershISP and learn new ways of working better and smarter. These things take time. However, the need for system reform has never been greater. The Division prepares quarterly reports for the Legislative Oversight Committee describing implementation progress. Each of these reports and other details about reform implementation are available on the Department web site at: http://www.dhhs.state.nc.us/mhplan/

A summary of the numbers of people in North Carolina who have disabilities and need services, supports and treatment is briefly described below.

SUMMARY OF NEEDS - ADULT MENTAL HEALTH

Prevalence

According to estimates by the federal Center for Mental Health Services, during a 12-month period, approximately 5.4 percent of the adult population has a serious mental illness. This means that in North Carolina, during a 12-month period, approximately 322,000 adults have a diagnosable mental, emotional or behavioral disorder that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Within this population, approximately 99,000 have severe and persistent mental illnesses (SPMI) that interfere substantially with their ability to manage the demands of daily living.

Population being served

Current numbers of people being served/supported do not approach estimates of need projected for our state's population. In 1999-2000, area programs provided mental health treatment to 152,744 adults. Of that total, 24,764 were described as people with serious and persistent mental illness.

Of the total number of adults served by area programs, 88,844 were females, and 63,767 were males. Twenty-nine percent were African-American, 66 percent white and less than one percent of Hispanic origin. It should be noted that Hispanic individuals are underrepresented in the service

population. This group makes up over four percent of the adult population in NC, but less than one percent of the client population in the public mental health system. Given the projected rapid growth in the state's Hispanic population, this is an area in need of attention, as are other underrepresented minorities.

SUMMARY OF NEEDS - CHILD MENTAL HEALTH

Prevalence

North Carolina conservatively estimates 10 to 12 percent of the state's children experience serious emotional disturbance (SED). This is based on the prevalence rate cited in the June 1998 *Federal Register*. The NC Office of State Planning estimated in 1997 that there are 1,730,695 children in NC under age 18. The number of children in this age group with SED is between 173,069 and 207,683.

Population being served

In 1999, area programs served 78,185 children and adolescents with, or at risk for, serious emotional disturbance. This represents a two percent increase over the previous year. Year 2000 data show 64,698 children served; however, this apparent decrease actually occurred due to a mid-year change in reporting systems. Approximately 2,941 children/youth served in 2001 have or are at risk for SED and at risk for out-of-home placements. These youth are predominantly male (76.6 percent male and 23.4 percent female). Among children served, 39 percent are African-American, 56.5 percent are White and 4.5 percent are described as "other."

The disparity between children served in any year and reliable estimates of need is enormous.

TABLE 1: AGES OF CHILDREN SERVED BY AREA PROGRAMS

Age	*Percent Female*	*Percent Male*	*Total Number*	*Total Percent*
Birth - 2	7.09	6.25	5,032	6.58
3 - 5	10.33	10.68	8,062	10.54
6 - 11	41.93	48.04	34, 931	45.67
12 - 17	40.65	35.03	28,460	37.21

Children with multiple diagnoses

Children with multiple diagnoses are included as a priority within target populations. In FY98, the total number of children was 76,485. Of them, 86 percent had two or more diagnoses, and 49 percent had three or more. Individuals with multiple disabilities typically require ongoing, integrated and comprehensive support for more than one major life activity in order to participate in community settings and enjoy the quality of life experienced by youngsters with fewer or no disabilities.

Multiple service systems (Department of Public Instruction, Departments of Social Services, Department of Juvenile Justice and Delinquency Prevention, etc.) serve these youth. Children and youth with multiple disabilities may exhibit a wide range of characteristics depending on the combination and severity of their disabilities and their age. Disabilities may include limited speech or communication, tendencies to forget skills, trouble generalizing skills and a need for support in a variety of life activities including leisure, vocational and community participation.

SUMMARY OF NEEDS - DEVELOPMENTAL DISABILITIES

Prevalence

The Division's developmental disabilities services section follows recommendations of the National Association of State Directors of Developmental Disabilities Services and uses the University of Minnesota's figure of 1.58 percent as a broad estimate of people in the total population with developmental disabilities. Of these, estimates are that .79 percent are adults and approximately three percent are children. This means that there are approximately 130,810 people in NC with developmental disabilities.

Population being served

North Carolina's developmental disabilities system is at a crossroads in its evolution. It is a system that provides an extensive array of services and supports in its quest to meet the needs and preferences of the individuals it serves. The system provides services and supports to approximately 30,000 children and adults across the state. North Carolina's Home and Community-Based Waiver supports approximately 5,700 of these 30,000(in NC, the HCBS waiver is known as CAP-MR/DD). In addition, developmental disability programs across the state keep an up-to-date waiting list of individuals in services who have requested new or additional services and people who are seeking services that are not available within existing resources.

Community services have expanded through an increase in the HCBS waiver (CAP-MR/DD) by 300 percent and increased state dollars appropriated for services. North Carolina rates among the top 10 states in the nation for the amount of funds used for family support. Over the past ten years, North Carolina has reduced the census of its public mental retardation centers through a planned system of downsizing. The state continues, however, to overly rely on public and private group care for people with developmental disabilities.

SUMMARY OF NEEDS - SUBSTANCE ABUSE

Prevalence

Data used in making projections of treatment needs are taken from North Carolina's first Center for Substance Abuse Treatment (CSAT) needs assessment studies conducted by the Research Triangle Institute. Estimates of people needing substance abuse services include:

- 784,000 people age 18 and above who needed substance abuse services.
- 2,600 homeless.
- 2,700 psychiatric patients.
- 9,700 imprisoned believed to be in need of substance abuse services.
- 47,555 public high school students.
- 4,917 school dropouts.
- 666 private school students.

Population being served

North Carolina's public substance abuse service system is hospital and community-based, providing education, prevention, early intervention and treatment services to the state's residents. In fiscal year 2000, the public system served more than 88,000 adults and children throughout North Carolina's 100 counties. However, this figure represents less than one percent of the identified need. Substance abuse treatment and services account for only six percent of the overall funding for mh/dd/sa services, but the broader costs of untreated substance abuse related problems such as lost days worked, arrests, injuries and illnesses, family violence and other serious problems, multiply the state's total investment in substance abuse issues many times over.

ADDRESSING DISPARITIES IN THE MH/DD/SA SYSTEM

Minority and ethnic groups are disproportionately represented within the present system. For example, according to the recently released Client Statistical Profile for 2000-2001, African-Americans made up 33.8 percent of persons served, or 61.1 per 1,000, the highest rate relative to their respective statewide population of 21.6 percent. The Hispanic/Latino population represents 4.7 percent of residents statewide, but only 1.39 percent of active service recipients, or 11.5 per 1,000. There may be many reasons for variations in minority representation. These may include cultural and socioeconomic issues as well as concerns about stigma or negative attitudes toward people with disabilities.

- Strategies that local systems can use in addressing these disparities include:
- Publishing written materials in languages reflective of the local population.
- Collaborating with the Minority Health Advisory Council on addressing barriers to services in local systems.
- Developing cultural competency.
- Using bi-lingual services as a paid skill.

- Making special efforts to recruit and hire qualified workers from different ethnic/racial groups.

Part of the local planning process leading to local business plans should be a thorough examination of the socioeconomic and ethnic/racial composition of each region and creation of strategies for meeting these special needs. Issues related to access to services and disparities in consumer outcomes by race/ethnicity, gender, sexual orientation, age, disability, geographical location, income and education level will be tracked as part of the outcomes system and will be included in *report cards*, published reports on outcomes. The *Client Statistical Profile for 2000-2001* is available for review on the Department web site at http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm#Annual